## General Assistance Medical Program

## Request for Therapy Providers Tax ID Number:

| Date:   | Providers Tax ID Number:        |  |                           |   |     |
|---|---------------------------------|--|---------------------------|---|-----|
| Provider:   | Phone No:                       | Fax No   |                           |   |     |
| Patient Name (last name first): D.O.B. SSN.   |                                 | GAMP Effective Da                                  | ates:                     | 0:  |     |
| Medical Diagnosis:  Request for: □ OT □ PT □ Speed  Date of Initial Evaluation:  Number of Visits to date at your site: | ch □ Cardiac Rehab              | Previous treatment site Applicable):  # of Visits: | e for this                | diagnosis (if   |     |
| Part A Problem List   |                                 | Procedures   | perce<br>date             | e include<br>entage of goals t<br>with additional<br>nation and notes       |     |
| Short Term Goals  1. 2.   |                                 | Expected   | Complet                   | ion Date  |     |
| 3. Long Term Goals 1. 2. 3.   |                                 | Expected   | Comple                    | tion Date   |     |
| Part B FOR ADDITIONAL VISITS COM Long Term Goals  1.  |                                 |  | first v<br>and y<br>thera | olete part B if the isits are not end ou feel additionary visits are ssary. | ugh |
| 2. 3. Requested Frequency/Duration  |                                 |  |                           | 9/0   | Ī   |
| Please send progress notes from:  ***********************************   | zation Management u             |  | *****                     | **  |     |
| Todays Date: Signature:   | Authorizat<br>Visits Authorizat |  |                           |   |     |

. Authorized Fee at GAMP Reimbursement Schedule.